Issue Paper 1: Barriers to HIV Counseling and Testing
DRAFT

PROBLEM STATEMENT: In 2001, the Centers for Disease Control and Prevention (CDC) issued new guidelines for HIV counseling, testing, and referral.[1] These new guidelines emphasized the importance of early knowledge of HIV status and making HIV testing more accessible and available. In addition, the guidelines acknowledged providers' need for flexibility in implementing the guidelines, given their particular client base, setting, HIV prevalence level, and available resources, as well as clients' needs.

New developments in the HIV epidemic make the concern about decreasing barriers to HIV testing compelling. The advent of highly effective antiretroviral treatment has resulted in a reduction of a person's risk for HIV-related illness and death. In addition, early knowledge of HIV infection is important in controlling the spread of HIV infection because many infected persons modify behaviors that transmit HIV to sex or needle-sharing partners once they are aware they are HIV-infected. Early referral to medical care and treatment that lowers HIV viral load might also reduce risk for transmission to others.

Current rules for HIV counseling and testing in Washington, developed when there was no effective treatment, present a barrier to more widespread use of HIV testing.

DISCUSSION: Because of the increased time needed to counsel patients, as well as issues of training, liability, harm, and inadequate reimbursement, providers have found some elements in RCW and WAC to impose barriers to HIV testing. In addition, some patients at high risk avoid HIV testing because of the counseling requirements. Specific concerns include:

- A separate and specific informed consent process is required before HIV C/T can be performed. Although Washington law and rules do not specifically require consent be written, risk managers of most major health plans advise and require a special form and written consent. Private providers report that these processes require extra time and may increase patient concerns, resulting in hesitancy to recommend and accept testing.
- Voluminous counseling requirements. In the late 1980's, the Department of Health issued a 43-page booklet which identified four standards for risk assessment, eight criteria to determine counseling needs for persons at "virtually no risk of HIV infection", seven counseling standards (which require that up to 13 criteria be applied) for persons with some risk for HIV, and an additional three questions and counseling messages. Practicing physicians complain that these lengthy requirements for HIV pre-test counseling lead them to avoid asking questions about risk or suggesting HIV C/T to their patients.
- Studies have shown that when HIV testing is routine**,** and a special consent for testing is not required, it is acceptable to patients, and more people find out their HIV status.[2]
- Studies have shown that some people will delay HIV testing because they do not want to go through the associated counseling.[3]
- Since 1988, counseling strategies have evolved from an emphasis on information-giving to client-centered behavior change. These newer strategies are not reflected in the current RCWs and WACs.
- The CDC recommends encouraging client-centered counseling, when possible, but not when it prevents the provision or acceptance of HIV testing.[1]
- The CDC recommends making rapid testing available[4] to populations at high risk since this test is more effective and more cost-effective for providing knowledge of serostatus. Changes in technology, e.g., new rapid tests, are not reflected in the current RCWs.

Please direct questions and comments to Dennis Klukan, MSEPH, chair
Dennis.klukan@co.yakima.wa.us

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With the advent of HAART*, the knowledge of one's HIV seropositivity may now be life-saving. The CDC's Strategic Plan 2005 goal is to increase the proportion of persons with HIV who know their status from the current 66-75% to 95%. Changes in the WAC and RCW could help accomplish that goal.

* HAART: highly active antiretroviral therapy

[1] Centers for Disease Control and Prevention (2001b). Revised guidelines for HIV counseling, testing, and referral. *MMWR Recommendations and Reports, 50*(RR-19), 1-57. (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm).

[2] Branson BM, Lee JH, Mitchell B, Robbins A, Thomas MC. Targeted Opt-In Vs. Routine Opt-Out HIV Testing In Std Clinics. International Society for Sexually Transmitted Diseases Research Annual Conference. Denver, 1999 [abstract #052].

[3] Spielberg F, Branson B, Goldbaum G, Lockhart D, Kurth A, Celum C, Rossini A, Critchlow C, Wood R. Overcoming Barriers to HIV Testing: Preferences for New Strategies Among Clients of a Needle Exchange, an STD Clinic and Sex Venues for MSM. JAIDS 2002. In press.

[4] Centers for Disease Control and Prevention. Update: HIV counseling and testing using rapid tests—United States, 1995. *Morb Mortal Wkly Rep* 1998;47:211-5.

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